Dental History

Reason for visit:____

____

Date of last dental visit:____

Date of last dental X-rays:_______________________________________

How often do you floss?:____

How often do you brush?:____

Please answer **YES** or **NO** to the following:

Bad Breath	**Yes**	**No**
Bleeding, Red, Swollen Gums	**Yes**	**No**
Broken/Loose teeth or fillings	**Yes**	**No**
Clicking or popping jaw	**Yes**	**No**
Grinding teeth	**Yes**	**No**
Pain around ear/side of face	**Yes**	**No**
Sores/Blisters in mouth	**Yes**	**No**

List any other dental concerns/pain:

____

____

What did you like the most about your previous dental office?:

____

____

What did you like the least about your previous dental office?:

____

____

Are you interested in whitening your smile? **Yes** **No**

Are you happy with your smile? If not, what would you change?:

____

____

Patient Signature: ______________________________ Date Signed:________________